SOUTHLAKE PEDIATRICS

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Date: ____________________

Please list all children seen at this practice:

Name: ________________________________ Sex: ___M ___F Date of Birth: ______________
Drug Allergies? ________________________________

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Drug Allergies? ________________________________

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Drug Allergies? ________________________________

Name: ________________________________ Sex: ___M ___F Date of Birth: ______________
Drug Allergies? ________________________________

Children(s) Home Address:

Street Name: ________________________________

City: ______________________ State: ________ Zip: ______________

Mother's Name: ______________ DOB: ________ **Father's Name**: ______________ DOB: ________

Mother's Place of Employment: ______________________ Mom's Social Sec# ______________

Father's Place of Employment: ______________________ Dad's Social Sec# ______________

Mother's address if different: ________________________________

Father's address if different: ________________________________

If child doesn't live with parents, who is the primary caretaker? ______________________

Is this custody arrangement temporary or permanent? ______________ Primary Caretaker's # ______________

Phone Number	OK to leave message?	Phone Number	OK to leave message?
Home: ______________	☐ Yes ☐ No	Patient's cell: ______________	☐ Yes ☐ No
Mom cell: ______________	☐ Yes ☐ No	Mom work: ______________	☐ Yes ☐ No
Dad cell: ______________	☐ Yes ☐ No	Dad work: ______________	☐ Yes ☐ No
		Guardian: ______________	☐ Yes ☐ No

Primary caretaker's **EMAIL ADDRESS**: ________________________________

Emergency Contact (Someone NOT in the home): ______________________ Phone: ______________

Address: ______________________ City: ______________ State: _____ Zip: ________

Insurance #1 (Primary): ______________________ Co-Pay: ______ Contract#: ______________

Insurance #2 (Secondary): ______________________ Co-Pay: ______ Contract#: ______________

CONSENT OF TREATMENT – RELEASE OF MEDICAL INFORMATION – FINANCIAL RESPONSIBILITY

I consent to treatment for the care of the above named patient. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Southlake Pediatrics, Inc. In the event an account is not paid within 90 days, I agree to pay collection fees ($10 certified mail fee, collection agency fees not to exceed 33 1/3% & possibly attorney's fees) and hereby waiver all rights of exemption under the constitution of the state of Alabama.

Date: ______________ Signed: ________________________________ Parent _____ Foster Parent _____ Guardian _____